The Garamendi Plan
Completing Workers' Compensation Reform

On September 12, 2003, the California Legislature passed omnibus workers' compensation reform legislation, which was signed by the Governor and becomes law January 1, 2004. This reform promises nearly $5 billion in one-time savings and an additional $5.5 billion in ongoing annual savings. My analysis indicates that workers' compensation pure premium rates should be decreased 14.9% below current levels. This results in an advisory pure premium rate level that is only 0.8% above July 2002 pure premium rates. However, for these savings to be realized, all participants in the workers' compensation system must live up to their responsibilities in implementing these reforms.

The 2003 workers' compensation reform is a very courageous and significant first step that addresses many of the largest cost drivers and moves us closer to a more functional, predictable and competitive workers' compensation market. However, while the Legislature can be proud of its recent accomplishments, the monumental task of workers' compensation reform is far from complete. As I have done since taking office, I will continue to make workers' compensation my top priority and I will work collaboratively with business, labor and the Legislature to return workers' compensation to the system originally envisioned in the historic bargain of 1913 -- a no-fault system that protects employers from liability and compensates injured workers equitably and efficiently. Below is a list of the issues that we must address in 2004 to complete that task.

Permanent Partial and Total Disability (PD)

Problem: The current system for determining an injured worker's level of disability (PD, PPD, TD) is highly subjective and inconsistent leading to increased litigation and irrational settlements in which small injuries receive too much and serious injuries too little. Similar injuries should receive consistent PD ratings. This is not currently the case in California's PD rating system.

Solution: California must develop a more equitable and consistent permanent disability rating system based on objective assessments of disability. Restructuring permanent disability must be the top priority for 2004 workers' compensation reform. This can be done by (1) creating a more standardized and consistent method for the determination of impairment, and (2) reducing the frictional costs in the dispute resolution process by incorporating an independent medical examiner. Both of these changes will simplify the system, generate more equitable, efficient and timely PD settlements, and lead to dramatically lower levels of litigation within the system. The Rand Study on PD commissioned by CHSWC (expected Feb. 2004) will provide the foundation for a more efficient method of determining impairment. The Legislature should take immediate action on legislation to improve the current system once this study is complete. PD reform should also address apportionment. An employer should not have to pay a second time for permanent disability that has already been awarded.

Utilization Management (IMR)

Problem: Overutilization of medical services is a major cost driver that does not necessarily aid injured workers, extends injury claims, and wastes medical treatment resources. Numerous interstate comparisons and California-specific studies have demonstrated that overutilization of medical treatment is a serious problem within California's workers' compensation system. The 2003 reforms made significant improvements in establishing effective medical utilization controls by implementing evidence-based medical treatment guidelines and placing hard caps on chiropractic and physical therapy treatments. Despite these significant improvements, there is still more that needs to be done to complete the reform.

Solution: To build upon the 2003 reforms, we propose developing a strong definition of "reasonable medical treatment" and a streamlined independent medical review (IMR) process. For the evidence-based clinical treatment guidelines to achieve full effect, they need to be accompanied by a strong definition of "reasonable medical treatment." To reduce litigation and get workers the most appropriate medical care, the new treatment guidelines should be supported by an IMR process where workers' compensation medical decisions are made by medical practitioners. For guidelines to be effective, it is also imperative for medical providers, insurers' claims staff, and Workers' Compensation Appeals Board (WCAB) judges to be quickly and thoroughly trained on implementation of the new medical treatment guidelines. While these evidence-based guidelines will be the accepted standard of treatment, the examiner can consider new or additional scientific evidence of efficacy to approve a treatment that exceeds the guidelines.

Anti-Fraud Measures

Problem: The current culture of California's workers' compensation system is one where abuse and fraud are widespread and serve as a cost driver in the system. This culture must change. The high premiums, low benefits, and overall inequity of the current workers' compensation system contribute to an environment that is highly vulnerable to fraud. Workers' compensation fraud includes abusive and fraudulent provider billing practices (up-coding, unbundling, prescription billing, durable equipment, and services not rendered), medical-legal mills, and applicant and insider fraud. Numerous factors exacerbate and perpetuate workers' compensation fraud, including personal and business economic hardship, public acceptance of insurance fraud, and inadequate resources (manpower and funding) to investigate insurance fraud cases. Some insurance companies have also been derelict in their responsibility to fight fraud. The lack of uniform methodology and standards for assessing and reporting suspected fraud is a contributing factor.

Solution: The California Department of Insurance (CDI) is restructuring its fraud and investigative units to improve coordination efforts and to prioritize workers' compensation cases. CDI is also improving its working relationship with district attorneys and other state, federal, and local law enforcement agencies with an emphasis on information sharing. As part of these anti-fraud efforts, CDI supports immunity for individuals reporting suspected fraud. CDI also proposes making uninsured employers subject to felony charges.

State Compensation Insurance Fund (SCIF or State Fund) Reform

Problem: Elimination of the minimum rate law in 1995 led to a vicious cycle of underpricing workers' compensation premiums. Since that time, more than two-dozen workers' compensation insurance companies have been placed in regulatory conservation, liquidation, or supervision. As these companies failed and competition dwindled, State Compensation Insurance Fund, the insurer of last resort, picked up the slack, growing from 20% of California's workers' compensation market in 2001 to well over 50% of the market today. The impact of this rapid growth has placed enormous strain on the organizational structure and financial position of State Fund. To correct these problems, State Fund must undertake a series of difficult, but necessary adjustments to build up its financial strength.

Solution: State Fund should implement the reforms recommended in the IBM consulting report as appropriate. It should shed business that can be placed elsewhere in the market. State Fund should carefully evaluate its rating plan making sure all accounts are properly priced and ensure that savings from the 2003 workers' compensation reforms are reflected in those rates. State Fund should take necessary steps to increase enrollment in the Kaiser Alliance program, in order to help control escalating health care costs. Also, current law requires that all five voting SCIF Board Members must be SCIF policyholders 12 months prior to being appointed to the SCIF Board and during their entire tenure on the Board. We support removal of the SCIF policyholder requirement for two of the voting SCIF Board Members. This freedom and flexibility would allow recruitment of specialized expertise and fresh perspectives for SCIF oversight.

Physician Fees Indexed to Medicare

Problem: The 2003 workers' compensation reform implemented a Medicare-indexed fee schedule for outpatient surgery clinics. However, it did not implement the Medicare-indexed structure for all medical services, specifically physician fees. California's current physician fee schedule is not tied to Medicare, is not regularly updated and does not accurately reflect the cost of care. Current law expects a state agency with inadequate funding and little experience to create and update complex medical fee schedules. Experience has proven it does not work.

Solution: Tying costs to the Medicare fee schedule makes sense. It will provide a payment standard, allow for consistent and timely updates to the fee schedules and lead to additional cost savings through lower administrative costs on implementing and updating the schedules. Indexing to Medicare does not mean services are limited to Medicare prices, rather it provides a familiar standard upon which medical fees can be indexed. The stability and predictability that a Medicare-indexed fee schedule provides will save money by allowing actuaries to more accurately predict costs and insurance companies to correctly set their premiums.

Irrational Penalty Structure

Problem: Penalties imposed on insurers for late and inadequate payment of claims should have a reasonable relationship to the violation. The current penalty structure is irrational, allowing penalties to be assessed against the species of benefits paid, both past and future, for the entire claim, rather than the specific amount of payment that was either delayed or refused. Consequently, in a case where $200,000 in medical benefits was paid, a late $10 payment on reimbursement for a prescription to an injured worker can result in a 10% penalty or $20,000. The current structure provides strong incentives to allege penalties in order to gain larger settlements resulting in inequitable penalties and unnecessary litigation. The 2003 reforms exempted CIGA from paying 5814 penalties on inherited claims, but the 5814 penalty structure was not addressed.

Solution: Require injured workers and their attorneys to timely and specifically report when they believe employers have unreasonably delayed or refused to pay benefits. Allow for disputes on unreasonably refused or delayed benefits to be resolved without litigation and payment of an immediate, no-fault 10% penalty based upon the amount that was refused or delayed. If the matter is disputed further, allow for the assessment of a larger 25% penalty on the amount in dispute or $500, whichever is greater. This would help create a more responsive and rational penalty structure that effectively deters the specific negative conduct of the insurer or employer. It would also significantly diminish the opportunity to allege unwarranted penalties and reduce unnecessary litigation.

Return to Work

Problem: The overall complexity of the workers' compensation system leads to miscommunication, misinformation and frustration for injured workers and employers. Furthermore, the current system often provides clearer incentives for injured workers to claim disability than to return to work quickly. The lack of communication and misguided incentives contribute to slower medical treatment, longer disability, and increased litigation.

Solution: The best outcome for an injured worker is to get them back to work as quickly as possible. It is the employers' responsibility to ensure this happens. We must restructure the system so that injured workers, employers and all other participants in the system have the proper incentives to return injured workers to work as quickly as possible. Benefit systems must be structured so that injured workers want to return to work and employers want to accept injured workers back, even in a modified capacity, as quickly as possible. Doctors must be appropriately compensated for the time to evaluate return to work. More coordination, collaboration, and integrated communication between doctors, injured workers, and employers focused on getting the injured worker back to work is imperative. HCOs, ombudsman, nurse case managers, and other similar programs all move the system in this direction. Changing incentives and improving communication will reduce time off work, permanent disability costs, and litigation costs.

Workers' Compensation Information System Reform

Problem: Currently, there is no extensive database of claims information available to analyze the efficiency of the system and detect outliers responsible for fraud and abuse in the system. The Department of Industrial Resources' Division of Workers' Compensation (DWC) is developing such a database as required by the passage of AB 749 in 2002. However, because of technical limitations, budget constraints and limited resources, DWC has not been able to develop this database in an efficient and timely manner.

Solution: The responsibility for developing and maintaining this database should be shifted from the DWC to the Workers' Compensation Insurance Rating Bureau (WCIRB). The WCIRB has the resources and technical capability to both develop and maintain the database and to conduct the analysis necessary to detect outliers and effectively use the information to combat fraud and abuse in the workers' compensation system.

Immediate Medical Treatment

Problem: For countless reasons, injured workers are too frequently denied the immediate, essential, and, often, basic medical treatment they are entitled to under the workers' compensation system. In nine out of ten cases, the injured worker is ultimately granted the medical care they or their physician initially requested. These unnecessary delays in medical treatment lead to unnecessary costs (increased medical, indemnity, and litigation). As untreated workers' medical conditions worsen, they take much longer to return to work, and they seek legal counsel to resolve the issues.

Solution: The employer must be responsible for providing immediate medical treatment to all injured workers. Employers should have up to one year to deny a claim as opposed to the current 90 day period. Employers should be able to deny a claim for fraud at any time. Employers will be responsible for all medical treatment until the claim is denied.

Single Premium Health Care

Problem: Employers currently pay for workers' compensation medical costs which account for close to 60% of workers' compensation premiums or an estimated $13.8 billion in 2004. Most employers also pay for health care benefits for their employees.

Solution: Single premium health care would seek to integrate workers' compensation health costs and regular healthcare benefits into one system. This could lead to significant savings by eliminating duplication of administrative costs in these two systems and also eliminating legal costs related to determination of medical benefits.

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